

Insights to Coding and Data Quality

CMS releases OPPS Final Rule

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The Centers for Medicare and Medicaid (CMS) published the Outpatient Prospective Payment System (OPPS) Final Rule November 27, 2013. There are several important changes to OPPS effective January 1, 2014; HIM professionals are strongly encouraged to review the complete Final Rule in detail.

Summary of major areas of impact or concern

CMS continues to package hospital outpatient services to more closely resemble the Medicare inpatient prospective payment system and less like a fee schedule, including those services that are considered integral, ancillary, supportive, dependent, or adjunctive to the primary services provided. The five new categories of packaged services include:

- All drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure, including stress agents and the drug Cysview;
 1. All drugs and biologicals (including implantable biologicals) that function as supplies when used in a surgical procedure, including skin substitutes;
 2. Clinical diagnostic laboratory tests (other than molecular pathology tests), that are integral, ancillary, supportive, dependent, or adjunctive to the primary services provided will be packaged when provided on the same date of service as the primary service AND ordered by the same practitioner who ordered the primary service;
 3. All procedures described by add-on codes that are integral, ancillary, supportive, dependent, or adjunctive to the primary services provided will be packaged into the primary procedure APC (excluding drug administration add-on codes and add-on codes currently assigned to device-dependent APCs);
 4. Device removal procedure codes billed with surgical procedures involving device repair or replacement will be packaged into the repair/replacement APC.
- All hospital outpatient clinic visits under the OPPS have a new alphanumeric HCPCS code, G0463 (Hospital outpatient clinic visit for assessment and management of a patient). The new HCPCS code is assigned to new APC 0634. The Final Rule also eliminated the distinction between new and established patient clinic visits. CMS final rule did NOT finalize the proposal to replace the current five levels of E/M codes for each type of emergency department visits and clinic visits. CMS will consider options to improve the codes for these services in the future.

The final rule will appear in the December 10, 2013 Federal Register and can be downloaded from the Federal Register at: [http:// www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1](http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1).

Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Parts 405, 410, 412, 419, 475, 476, 486 and 495 [http://www.ofr.gov/\(X\(1\)S\(1gfcpef2wogdakwu4rniktfi\)\)/OFRUpload/OFRData/2013-28737_PI.pdf](http://www.ofr.gov/(X(1)S(1gfcpef2wogdakwu4rniktfi))/OFRUpload/OFRData/2013-28737_PI.pdf)
CMS Fact Sheet: MS Issues Hospital Outpatient Department and Ambulatory Surgical Center Policy and Payment Changes for 2014

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-11-27-3.html>

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